



HealthPartners®

Date Completed: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_

**HEADACHE History:**

On average you have headache how many **days/month**? \_\_\_\_\_

On average how many **days/month** is pain **moderate or severe**? \_\_\_\_\_

If you take an **acute pain drug** for your headaches how many **days/month**? \_\_\_\_\_

Do headaches start so quickly they reach maximum in < 2 minutes and then persist?  No  Yes

Have headaches occurred only a certain time of day or been dependent on your body position?  No  Yes

Is current headache different than in the past?  No  Yes If yes, how? \_\_\_\_\_

- \_\_\_\_\_ 1. How many days in the last 3 months did you miss work or school because of your headaches?
- \_\_\_\_\_ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)
- \_\_\_\_\_ 3. How many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?
- \_\_\_\_\_ 4. How many days in the last 3 months was your productivity in household work reduced by half or more? (Do not include days you counted in question 3 where you did not do household work.)
- \_\_\_\_\_ 5. How many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

**Headache Description (if needing to describe additional headaches use back of form or additional paper):**

Headache Type You call your headache or consider the cause to be?	Type #1 _____	Type #2 _____	Type #3 _____
How bad does this headache pain usually get: 1 = mild; 2 = moderate; 3 = severe/unbearable	1            2            3	1            2            3	1            2            3
When or at what age did you first get this headache?			
How many mins, hrs, days or wks does your pain usually last?	____ minutes ____ hours ____ days      ____ weeks	____ minutes ____ hours ____ days      ____ weeks	____ minutes ____ hours ____ days      ____ weeks
Where does your head hurt? (Check all that apply)	<input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> All over <input type="checkbox"/> Variable <input type="checkbox"/> Front,forehead <input type="checkbox"/> Eye <input type="checkbox"/> Back or near the neck <input type="checkbox"/> Top of head <input type="checkbox"/> Face,jaw	<input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> All over <input type="checkbox"/> Variable <input type="checkbox"/> Front,forehead <input type="checkbox"/> Eye <input type="checkbox"/> Back or near the neck <input type="checkbox"/> Top of head <input type="checkbox"/> Face,jaw	<input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> All over <input type="checkbox"/> Variable <input type="checkbox"/> Front,forehead <input type="checkbox"/> Eye <input type="checkbox"/> Back or near the neck <input type="checkbox"/> Top of head <input type="checkbox"/> Face,jaw
How does the pain feel? (Check all that apply)	<input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Burning <input type="checkbox"/> Dull ache/Pressure/Viselike <input type="checkbox"/> Throbbing/ Pounding	<input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Burning <input type="checkbox"/> Dull ache/Pressure/Viselike <input type="checkbox"/> Throbbing/ Pounding	<input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Burning <input type="checkbox"/> Dull ache/Pressure/Viselike <input type="checkbox"/> Throbbing/ Pounding
Does this pain get worse with activity such as climbing stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What other symptoms do you get with this headache? (Check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Noise sensitivity <input type="checkbox"/> Smell sensitivity <input type="checkbox"/> Nausea or no appetite <input type="checkbox"/> I vomit <input type="checkbox"/> I have difficulty thinking <input type="checkbox"/> I feel dizzy; I spin <input type="checkbox"/> Tearing/Nasal Congestion <input type="checkbox"/> I am sensitive to hot or cold <input type="checkbox"/> Skin touch causes pain Other:	<input type="checkbox"/> None <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Noise sensitivity <input type="checkbox"/> Smell sensitivity <input type="checkbox"/> Nausea or no appetite <input type="checkbox"/> I vomit <input type="checkbox"/> I have difficulty thinking <input type="checkbox"/> I feel dizzy; I spin <input type="checkbox"/> Tearing/Nasal Congestion <input type="checkbox"/> I am sensitive to hot or cold <input type="checkbox"/> Skin touch causes pain Other:	<input type="checkbox"/> None <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Noise sensitivity <input type="checkbox"/> Smell sensitivity <input type="checkbox"/> Nausea or no appetite <input type="checkbox"/> I vomit <input type="checkbox"/> I have difficulty thinking <input type="checkbox"/> I feel dizzy; I spin <input type="checkbox"/> Tearing/Nasal Congestion <input type="checkbox"/> I am sensitive to hot or cold <input type="checkbox"/> Skin touch causes pain Other:
Do you have any visual changes (zigzag lines, flashing lights, tunnel vision) with this headache?	<input type="checkbox"/> Yes <input type="checkbox"/> No Circle or write changes below:	<input type="checkbox"/> Yes <input type="checkbox"/> No Circle or write changes below:	<input type="checkbox"/> Yes <input type="checkbox"/> No Circle or write changes below:

**Please check any of the following you feel may start or trigger your headaches** (Check all that apply): Alcohol ; Fasting ; Foods (list): \_\_\_\_\_ ; Odors ; Bright light ; Sun ; Altitude changes ; Seasonal changes ; Weather changes ; Clenching my jaw ; Sore jaw muscles ; Grinding teeth ; Too much sleep ; Changes in usual sleep pattern ; Lack of sleep ; Restless legs ; Exertion (such as climbing up stairs) ; Stress ; Vacations ; Weekends ; Let-down periods (following a big event) ; Allergies or sinus problems ; Hormones ; Menstrual periods .

How often do you think you know what triggered your headache?  <25%  25 – 50%  50 – 75%  75 – 100%

**Your Family History:**

Any family history of headaches?  No  Yes If yes, who? \_\_\_\_\_  
 Any family history of nervous system problems such as depression, anxiety? If yes, who? \_\_\_\_\_

**Your Medical History:**

Motor vehicle accident(s):  No  Yes Year(s) \_\_\_\_\_ Injuries:  No  Yes Headache changes:  No  Yes  
 Litigation over the MVA?  No  Yes. Are you on disability for any reason? No Yes

**Social-Psychological History:**

My marital status: Single Married (first second) Significant Other Divorced Widowed

Number of children I have? \_\_\_ Ages \_\_\_\_\_

My occupation: \_\_\_\_\_ # years: \_\_\_\_\_ # hours per week: \_\_\_\_\_

The most important stressors in my life are: \_\_\_\_\_

I have/or had depression anxiety post-traumatic stress Abuse: sexual, physical, emotional

Suicidal thoughts: Never had ; Currently have ; Have had in the past but don't now

**Lifestyle:**

How many hours of sleep per night? \_\_\_\_\_ Is sleep disturbed?  No  Yes **If yes, describe** \_\_\_\_\_

Do you have difficulty falling asleep, teeth clenching or snoring?  No  Yes

How many days/week do you practice any relaxation techniques? \_\_\_\_\_ Describe \_\_\_\_\_

How many drinks/cups per day of a caffeinated beverage do you consume? \_\_\_\_\_

Do you have any artificial sweeteners-aspartame, sucralose and truvia/stevia.  No  Yes Do you use Sudafed, Actifed, Pseudoephedrine, Claritin D, etc.?  No  Yes

How many meals do you eat per day? \_\_\_\_\_ Are these regular meals without skipping?  No  Yes

How many days per week do you exercise? \_\_\_\_\_ If so, what type and for how long \_\_\_\_\_

How many ounces of fluid do you drink per day? \_\_\_\_\_ What do you drink? \_\_\_\_\_

**Substance Use:**

**Do you use tobacco?**  No  Yes If yes, how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you use alcohol?  No  Yes - how many drinks per week? \_\_\_\_\_ Do you use marijuana or other?  No  Yes

**Check all daily preventative medications you have taken before for headache (Obtain your pharmacy records for use):**

- |                                                  |                                                  |                                                   |
|--------------------------------------------------|--------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Elavil – amitriptyline  | <input type="checkbox"/> Tenormin – atenolol     | <input type="checkbox"/> Depakote – valproic acid |
| <input type="checkbox"/> Pamelor – nortriptyline | <input type="checkbox"/> Inderal – propranolol   | <input type="checkbox"/> Lamictal – lamotrigine   |
| <input type="checkbox"/> Norpramin – despiramine | <input type="checkbox"/> Lopressor – metoprolol  | <input type="checkbox"/> Lyrica – pregabalin      |
| <input type="checkbox"/> Cymbalta – duloxetine   | <input type="checkbox"/> Calan – verapamil       | <input type="checkbox"/> Neurontin – gabapentin   |
| <input type="checkbox"/> Deseryl – trazodone     | <input type="checkbox"/> Cardizem diltiazem      | <input type="checkbox"/> Topamax – topiramate     |
| <input type="checkbox"/> Effexor – venlafaxine   | <input type="checkbox"/> Norvasc – amlodipine    | <input type="checkbox"/> Zonegran – zonisamide    |
| <input type="checkbox"/> Paxil – paroxetine      | <input type="checkbox"/> Indocin – indomethacin  | <input type="checkbox"/> CoEnzyme Q10             |
| <input type="checkbox"/> Prozac – fluoxetine     | <input type="checkbox"/> Magnesium               | <input type="checkbox"/> Namenda – memantine      |
| <input type="checkbox"/> Wellbutrin – bupropion  | <input type="checkbox"/> Petadolex – butterbur   | <input type="checkbox"/> Diamox – acetazolamide   |
| <input type="checkbox"/> Zoloft – sertraline     | <input type="checkbox"/> Vitamin B2 – riboflavin | <input type="checkbox"/> Botox A                  |

**Check all acute pain meds you have taken before for headache (Use your pharmacy records if available):**

- |                                                  |                                                   |                                                        |
|--------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> Amerge – naratriptan     | <input type="checkbox"/> Prednisone                    |
| <input type="checkbox"/> Tylenol – acetaminophen | <input type="checkbox"/> Axert – Almotriptan      | <input type="checkbox"/> Medrol dose pack              |
| <input type="checkbox"/> Advil – ibuprofen       | <input type="checkbox"/> Frova – frovatriptan     | <input type="checkbox"/> Reglan – metoclopramide       |
| <input type="checkbox"/> Excedrin Migraine       | <input type="checkbox"/> Imitrex – sumatriptan    | <input type="checkbox"/> Zofran                        |
| <input type="checkbox"/> Indocin indomethacin    | <input type="checkbox"/> Maxalt/MLT – rizatriptan | <input type="checkbox"/> Phenergan                     |
| <input type="checkbox"/> Aleve/Naproxen          | <input type="checkbox"/> Relpax – eletriptan      | <input type="checkbox"/> Compazine – Prochlorperazine  |
| <input type="checkbox"/> Toradol – ketorolac     | <input type="checkbox"/> Zomig/ZMT – zolmatriptan | <input type="checkbox"/> Lidocaine nose drops          |
| <input type="checkbox"/> Cafergot – ergotamine   | <input type="checkbox"/> Migranal NS – DHE NS     | <input type="checkbox"/> Stadol NS – butorphanol       |
| <input type="checkbox"/> Midrin – isometheptene  | <input type="checkbox"/> DHE- 45                  | <input type="checkbox"/> Fioricet/Fiorinal/bultalbital |

Muscle relaxers: \_\_\_\_\_ Pain medications/Opioids: \_\_\_\_\_

OTHER: \_\_\_\_\_

**Previous Headache Care:**

Please list all physicians you have seen for Headache Care, and Testing (example: MRI brain, CT head, etc). If records are outside of Park Nicollet, Health Partners, Fairview, Allina please request those records be faxed to 952-993-5063 or hand carry to appointment if needed due to timing.

**Complete Review of Systems History**

Please check all symptoms that apply to you **within the past month:**



**REVIEW OF SYSTEMS – CHECK BOX as Appropriate:**

	Present	Present	
<b>GENERAL HEALTH</b>	<input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Sweats	<input type="checkbox"/> Malaise <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight change	
<b>EYES</b>	<input type="checkbox"/> Visual acuity <input type="checkbox"/> Redness	<input type="checkbox"/> Holes in vision	
<b>ENT</b>	<input type="checkbox"/> Double vision <input type="checkbox"/> Sore throat <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Nose drainage	<input type="checkbox"/> Tooth pain <input type="checkbox"/> Earache <input type="checkbox"/> Hearing loss <input type="checkbox"/> Vertigo (Spinning or Sense of Motion)	
<b>BREATHING</b>	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing	<input type="checkbox"/> Sputum <input type="checkbox"/> Cough Up Blood	
<b>HEART</b>	<input type="checkbox"/> Chest pain <input type="checkbox"/> Extra heart beats <input type="checkbox"/> Faint/syncope <input type="checkbox"/> Snores	<input type="checkbox"/> Shortness of Breath When Lying Down <input type="checkbox"/> Swelling in the Feet or Legs <input type="checkbox"/> Inflammation in a Vein(s)	
<b>GI/BOWELS</b>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in Sputum <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Yellow Eyes or Skin (Jaundice)	
<b>GENITALS/ URINE</b>	<input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Incontinence	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Painful Menstrual Periods <input type="checkbox"/> Testicle Pain/Swelling	Last Menstrual Period: _____
<b>MUSCLES/BONES</b>	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Range Of Motion Limitation <input type="checkbox"/> Falls	
<b>SKIN</b>	<input type="checkbox"/> Rash <input type="checkbox"/> Lesions/Sores	<input type="checkbox"/> Itching	
<b>NERVOUS SYSTEM</b>	<input type="checkbox"/> Altered or LOC <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness/Paralysed	<input type="checkbox"/> Tremor <input type="checkbox"/> Seizure <input type="checkbox"/> Memory problems	
<b>MENTAL HEALTH</b>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia <input type="checkbox"/> Hallucination	
<b>ENDOCRINE</b>	<input type="checkbox"/> Frequent Drinking <input type="checkbox"/> ↑ Urine Volume	<input type="checkbox"/> Frequent Eating <input type="checkbox"/> Hot or Cold intolerance.	
<b>BLOOD SYSTEM</b>	<input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged Lymph Nodes	<input type="checkbox"/> Bruising/Bleeding	
<b>ALLERGY</b>	<input type="checkbox"/> Dermatitis <input type="checkbox"/> Hives <input type="checkbox"/> Runny Nose	<input type="checkbox"/> Pollens, dander <input type="checkbox"/> Previous PPD positive (TB test) <input type="checkbox"/> Previous positive skin tests	